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ABSTRACT

The benefits of family level intervention programs for parents of young handicapped or "at-risk" children are pointed out. Fundamental prerequisites for the success of such programs are outlined, findings of research regarding the setting up of family level intervention programs are listed, and a framework for such a program is offered. Techniques for dealing with parents attitudes are explored. (SBH)

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CHANGING ATTITUDES OF PARENTS - JOHN McKENNA

Prior to World War 11, most programmes of special education were based on the assumption that elimination of competition with pupils of normal ability would mitigate the lot of the handicapped, promoting their education, progress and general welfare. The consequences of this was a special type of social isolation which further aggravated the condition of handicapped persons by making integration into the community or work force difficult in many cases and almost impossible in some. In special education the training of teachers in many places contributed to the sense of isolation since the traditional pattern of training was, and still is in some places, directed towards one area of handicap. That is, teachers in special education were categorized as teachers of the deaf, teachers of the blind, teachers of the mentally handicapped, etc. Different forms of handicap and different levels of mental handicap generated their own specific needs, creating their own special training programmes for personnel. segregated from broad generic services. Thus administrative development lacking any systematic approach or coherent theory of management was often reflected in the imbalance between needs and resources.

The immediate aftermath of World War 11 marked a watershed in the history of special education. A new dynamic reenforced the drive to supply the needs of exceptional children. This originated in the frustration of parents of handicapped children brought about by the institutional neglect of their children's needs, the lack of services and the poor quality of

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existing services. The Parent Movement was essentially one of protest against the negative attitudes of policy-makers, administrators and professionals towards the provision of facilities for those with sensory, mental and physical handicaps. It critized the lack of facilities and the quality of provisions but not necessarily the kind of services provided. Since the major thrust of resources had been directed towards hospital-based or sickness-oriented facilities, the existing models had a strong influence on parents' demands. Pressures were exerted upon authorities for the provision of more residential facilities and the construction of large complexes especially for severely and moderately mentally handicapped individuals received enthusiastic support.

While parents' demands were more readily met this did not necessarily mean that the real needs of their children were met. Needs are different from demands: they require formulation by professionals. In the 40's, professionals with a deep interest in special education were few and professionals with specific research-based knowledge of human development and growth and its application to the needs of exceptional children were even rarer. The position has changed radically since then. Now in most progressive countries parentsand professionals are cooperating with each other and when professionals seek support for the extension of special facilities, it is frequently Parent groups who are their readiest advocates exerting pressures on the policy-makers who control the budgets. Today of course the drive is for new methods and types of services, for innovative approaches and for community-based facilities many of them taking their inspiration from the concept of 'normalization'.

But the time has come to direct more attention to the role of parents of the exceptional children in the formal educational process of their children. With our increased knowledge of the nature of early development and of the effects of parents

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and home upon the actual structural development of the cortex and upon the general personality development, a more systematic approach could be profitably adopted to the education of parents in stimulating and favourable child-rearing practices, especially in the case of 'at risk' children with initial physical or sensory handicaps. The natural inclination of parents to care for their children augmented by systematic programmes of parent instruction to offset the effects of primary handicaps, could be a most effective force in reducing the unfavourable consequences of such handicaps. In special education one of the primary objectives of the next decade may well become the modification and restructuring of child-rearing patterns with parents of exceptional children so that their children can reap the benefits of compensatory programmes and of subsequent educational programmes.(McKenna 1973).

This idea is by no means a new one. In many parts of the world individual teachers, psychologists, social workers, nurses, workers in what are termed the "caring" professions have been passing on their skills to parents and groups have been conducting evaluative research in compensatory programmes. For example, the Infant Education Centre at the University of Wisconsin found that mental retardation was not randomly distributed in areas of poverty but was confined to a small proportion of families living in the poverty environment. A systematic attempt was made with an experimental group to modify the mothers' interaction with their new born infants by remediating anything perceived as a deficit or deprivation of opportunities to learn intellectual skills. The programme was precisely structured and designed to facilitate the emergence of cognitive skills, comprising the development of linguistic skills,problem-solving skills and achievement motivation. The results were sufficiently promising to give hope to many who were attempting similar approaches in many places as well as in U.S.A. (Heber 1972). In fact the position in U.S.A. is that it is now lawful to provide services to

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family members when they are essential to the disabled person's vocational rehabilitation. (Pacinelli 1978).

There are many programmes, based on the work of Piaget and Bruner, which attempt to facilitate development through systematic provision of specific experiences. It has been amply demonstrated that motor, perceptual and cognitive functioning, as well as personal social attributes can be accelerated in children at many age levels and of all social and ethnic groups. Again, the active involvement of parents in such programmes is not a new idea.

Perhaps the time has come for the idea to be embodied in mandatory rather than enabling legislation - an injunction upon all Governments where possible to reserve funds for the earliest ascertainment of developmental difficulties and for the provision of formal educational facilities for handicapped persons and their families from the time of ascertainment. Instead of reacting to the changing attitudes of parents, the time has now come for action on the part of professionals directed towards changing the attitudes of parents. On the basis of what is now known about early stimulation, parents can be given a new sense of their importance to their children: how they can substantially improve cognitive skills and personal-social attributes in more systematic ways and how they with guidance are in the best position to accomplish this.

There are three fundamental prerequisites for the success of such programmes. The first is an effective system of health care. Education and health care are interdependent and mutually reenforcing. Prenatal nutritional defects in the mother's diet and poor nourishment in the early years of childhood may have lasting and irreversible effects on brain development.

The second requirement is for authorities to accept the

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responsibility for actual delivery of services, not just make them available. Often it is the parents most in need of help who fail to take advantage of existing services.

The third requirement is a programme of systematic public education to impress upon parents the necessity for immediate attention to any developmental anomalies and the responsibility they bear for their children's ultimate level of functioning. It is also important to bring about more positive attitudes in the public towards handicapped persons and to give more accurate information about their potential for growth and development.

The findings of research which are most relevant to setting up family level intervention programmes are:-

1) The family is the critical social institution for early development; parental attitudes to rearing practices, parental language styles and attitudes to achievement, play the most significant part in determining the child's future response to learning opportunities.

2) Sensory and physical handicaps with their possible systemic effects, emotionally disturbed and disorganized parents and poverty prevent children from realizing their genetic possibilities.

3) The earlier the onset of intervention programmes the more effective they are so that home-based programmes are most effective for long-term handicapping conditions.

4) Programmes directly involving parents as auxilliaries in a formal way have more lasting effects than those where parents are mere observers.

5) Not all families are capable of supplying a supportive environment for exceptional children so that strategies other than family intervention programmes must be considered. (Garber & Heber 1977).

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I would like now to share with you some more specific prescriptions which I have found most useful in family intervention programmes.

1) The mother is generally the most effective agent of change in family intervention programmes. Involve her from the start at the initial assessment interview. Make the administration of tests a demonstration of what her child can do and what you expect.

2) Insist that your findings are provisional - a base from which advances may be expected.

3) Share your opinions with the child's parents in terms readily understandable to them and show them any reports you may be sending say to the referring agency or individual.

4) Reduce the guilt feelings which are frequently found in the parents of exceptional children. Explain that difficult behaviour is often directly related to an initial handicap and to environmental difficulties over which parents have little control. The term "emotionally disturbed" is often felt to point the finger to the parents as the direct cause of the disturbance. In many cases "behaviourally disabled" is more accurate and less condemnatory.

5) Help parents to cope with negative attitudes they are bound to meet with from relations, from professionals, from administrators and from other children. These are the deficiencies of others not of their children. Attitudes and their consequences may be as prejudicial to children's development as any internal pathology they may have.

6) Plan a realistic programme for parent involvement in the teaching - learning process with frequent contact and reviews of progress.

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7) Teach the parents to give you feedback about their involvement and its effects by consistent recording - how much time per day in formal interaction?, what was the child's reaction?, their difficulties, their successes. etc. Parents who continually fail to keep any records are often unable to learn to apply techniques which have been demonstrated. This may indicate the need for more intensive support from external agencies.

8) Praise the parents for their successes; this helps to restore their feelings of self-confidence and competency as parents.

9) Show parents the relationship between childrens' responses and their consequences and demonstrate how they may decrease or eliminate inappropriate behaviour and increase desirable behaviour in a systematic way rather than inadvertently.

For the parents of very young 'at risk' infants it is very helpful to start them on a motor-training programme since early sensory-motor activity lays the basis for later cognitive skills. Piaget's sensory-motor sub-stages provide an excellent framework within which such a programme can be devised, e.g.

1) Reflexes for the first month. Promote sucking reflex, kicking, tonic neck reflex, palmar grasp and visual pursuit.

2) Primary Circular Reaction (1 - 4 months). Promote grasping, visual tracking, modification of reflexes.

3) Secondary Circular Reaction (4 - 8 months). Actions are now directed towards objects and events; noise making toys induce primitive notion of causality. Conceal or partially conceal objects to promote imagery, promote rapid eye movement.

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4) Coordination of Secondary Schema (8 - 12 months)
Definite intentionality may now be seen. Imitation of motor movements are apparent and concealed objects may be retrieved. Juxtaposition of finger and thumb and the release of objects in finger-thumb grasp takes place.

5) Tertiary Circular Reaction (12 - 18 months)
The child can now pursue novelty and can manipulate objects, identifying them when named pointing and sometimes naming. Social interaction takes place at a more differentiated level.

6) Invention of new means through Mental Combinations (18 months+)
Child is now capable of symbolic representations. Memory and imagery are apparent in the manipulation of more complicated toys and in games.

During the first year, especially with 'at risk' children, the availability of appropriate opportunities for interaction with objects and with others may not of itself be sufficient. Involvement of the child may require intensive and planned promotion and Bruner's three levels of representation suggest a systematic way in which attention and interaction may be achieved. These are:

(1) Enactive where, for example, objects are placed in the child's palm and the fingers are wrapped round in order to achieve palmar grasp - the motor activity is imposed so that the adult cortex is actually performing through the child's limbs.

(2) Iconic where demonstrations of the desired activity are performed to indicate what is wanted, and

(3) Symbolic where verbal instructions achieve compliance. While this last level is not fully effective until the second year of life, it is as well to encourage the parents to speak to the child as often as possible, for, although infants in their first year are unable to conceptualize, they are capable of social and emotional interaction which speech can encourage.

For older children with reading difficulties positive results are achieved by using the parents as auxilliary teachers and by employing psychological insights from many sources. This approach is multi-dimensionial and the main aspects are:

(1) Therapeutic. This requires the development of new attitudes in the pupil to the teaching-learning situation. It also prescribes new attitudes on the part of the parent towards their child's potential based on a more accurate assessment of this. Destructive parental attitudes which perpetuate the child's difficulty have to be eliminated.

(2) Traditional. Frequent drill, moving from the known to unknown, frequent rewards, the provision of a more object-rich environment - all the approaches used by a good teacher should be explained to the parent.

(3) Montessori. Provide the atmosphere for intense and lengthy concentration; all children are capable of responding appropriately to this. Small steps, frequent successes, elimination of punitive attitudes on the part of the parent.

(4) Language. Speech is the basis of reading. Direct the parents towards the importance of verbal communication with their children and demonstrate how they can help their children achieve improved linguistic competency. Use words and associated vocabulary to improve 'guessing'. skills or contextual meaning.

(5) Behaviouristic.

a) Demonstrate how basic word-recognition skills can be improved. Often when children cannot read a word they can identify it when it is read to them. e.g. If the teacher/parent uses the formula "Show me the word that says ...." then the child can correctly indicate the spoken word in print by using many minimal cues.

b) Demonstrate how positive attitudes and persistence at word recognition games can improve reading skills.

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c) Demonstrate how inappropriation behaviours may be diminished by relaxing, pleasant and satisfactory experiences.

d) Set a realistic target for the daily acquisition of so many new words which can be read, written and defined by the child. Let the child monitor his own successes, or failures, so that he may correct them.

e) See that the parents can account for each step and that they keep a diary of daily progress to provide the remedial helper with feedback about failures and successes so that the next week's/ month's programme can be devised accordingly. In this way you know how much time has been spent by the parents with their child's problem.

Any programme which increases competency in dealing with the difficulties of their own children increases their sense of adequacy as parents and this may be reflected in increased stability in the family as a unit. What any child will become depends largely upon the nature of the interaction between parents and child. Systematic programmes for improved parent/child interaction soundly based on current research are demonstrating their effectiveness in reducing the number of adults with problems. The time has come for professionals to change the attitudes of parents towards the importance of their role by their active involvement in formal educational processes as early as possible, and as much as is needed.

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